SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Filing at a Glance

Company: Golden Rule Insurance Company

Product Name: Individual Dental Policy	SERFF Tr Num: AMMS-125636345	State: ArkansasLH
TOI: H10I Individual Health - Dental	SERFF Status: Closed	State Tr Num: 38875
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: GRI-DEN1-03	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Jean Davis, Jennifer Konschake, Debra Schneider, Pam Devos, Sondra Grosse	Disposition Date: 06/23/2008
	Date Submitted: 05/06/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Dental policy	Status of Filing in Domicile:
Project Number: GRI-DEN1-03	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/23/2008	
State Status Changed: 06/23/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

See cover letter.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Jean Davis, Senior Product Compliance Analystjean.davis@eams.com
3100 AMS Blvd.
Green Bay, WI 54313
(800) 232-5432 [Phone]
(920) 661-6554[FAX]

Filing Company Information

Golden Rule Insurance Company	CoCode: 62286	State of Domicile: Indiana
7440 Woodland Drive	Group Code: 707	Company Type: Life and Health
Indianapolis, IN 46278	Group Name:	State ID Number:
(317) 297-0358 ext. [Phone]	FEIN Number: 37-6028756	

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Golden Rule Insurance Company	$100.00	05/06/2008	20119383

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/23/2008	06/23/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/07/2008	05/07/2008	Jean Davis	06/18/2008	06/18/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Extension	Note To Reviewer	Jean Davis	06/13/2008	06/13/2008
Objection Letter	Note To Filer	Rosalind Minor	06/13/2008	06/13/2008

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Disposition

Disposition Date: 06/23/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document *(revised)*	Application	Approved-Closed	Yes
Supporting Document	Application	Withdrawn	No
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form *(revised)*	Application	Approved-Closed	Yes
Form	Application	Withdrawn	No
Form *(revised)*	Dental Policy	Approved-Closed	Yes
Form	Dental Policy	Withdrawn	No
Form	Outline of coverage	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/07/2008
Submitted Date	05/07/2008
Respond By Date	

Dear Jean Davis,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application (Form)

Comment: The application should contain a Fraud Statement as required by ACA 23-66-503 and Bulletin 7-97.

Objection 2

- Dental Policy (Form)

Comment: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Objection 3

- Dental Policy (Form)

Comment: With respect to benefits payble a PPO and Non-PPO, it is requested that you provide written certification that benefits payable will comply with our Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between a PPO and Non-PPO.

Objection 4

- Dental Policy (Form)

Comment: There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/18/2008

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Submitted Date 06/18/2008

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Rosalind:

I am responding to your objection received May 7, 2008 in the same order.

Your objection
The application should contain a Fraud Statement as required by ACA 23-66-503 and Bulletin 7-97.
My response
The application has been amended to comply with ACA 23-66-503 and Bulleting 7-97 and an amended application has been attached. The application is now has a form number of DV-AP-130-03.

Your objection
With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.
My response
The policy has been amended on page 8 and an updated policy is attached for your review. Thank you.

Your objection
With respect to benefits payable at PPO and Non-PPO, it is requested that you provide written certification that benefits payable will comply with our Bulletin 9-85 which states there can be no more than a 25% differential in payment between a PPO and Non-PPO.
My response
Please accept this as written certification that in accordance with Bulletin 9-85 the difference between PPO and Non-PPO benefit levels will not exceed 25% for deductible, co-pay and coinsurance provisions.

Your objection
There needs to be a provision for refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.
My response
Please see Page 13 under the Termination Section, second column, for the required refund of unearned premium provision.

If you have any questions or need any additional information please contact me. Thank you for your time.

Sincerely,

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Jean

Related Objection 1

Applies To:

- Application (Form)

Comment:

The application should contain a Fraud Statement as required by ACA 23-66-503 and Bulletin 7-97.

Related Objection 2

Applies To:

- Dental Policy (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Related Objection 3

Applies To:

- Dental Policy (Form)

Comment:

With respect to benefits payble a PPO and Non-PPO, it is requested that you provide written certification that benefits payable will comply with our Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between a PPO and Non-PPO.

Related Objection 4

Applies To:

- Dental Policy (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application

Comment: An updated application is attached to the form schedule tab.

Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability	Attach

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

	Number	Date			Specific Data	Score	Document
Application	DV-AP-130-03		Application/Enrollment Form	Initial			AR dental stand alone app 6-08.pdf
Previous Version							
Application	*DV-AP-130*		*Application/Enrollment Form*	*Initial*			Dental application .pdf
Dental Policy	GRI-DEN1-03		Policy/Contract/Fraternal Certificate	Initial			AR policy 6-08.pdf
Previous Version							
Dental Policy	*GRI-DEN1-03*		*Policy/Contract/Fraternal Certificate*	*Initial*			AR dental policy.pdf

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

No Rate/Rule Schedule items changed.

Sincerely,

Debra Schneider, Jean Davis, Jennifer Konschake, Pam Devos, Sondra Grosse

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Note To Reviewer

Created By:

Jean Davis on 06/13/2008 02:25 PM

Subject:

Extension

Comments:

Thank you for your note Rosalind. I am planning to respond by June 27, 2008 but in case I am not able to finalize I would like to request an extension at this time. Thank you. Jean Davis

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Note To Filer

Created By:

Rosalind Minor on 06/13/2008 02:22 PM

Subject:

Objection Letter

Comments:

We have not received a response to our Objection Letter of 5/7/08.

If you need an extension, please let me know. If we do not here from you by June 27, 2008, the filing will be disapproved.

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Form Schedule

Lead Form Number: GRI-DEN1-03

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	DV-AP-130-03	Application/Enrollment Form	Application	Initial			AR dental stand alone app 6-08.pdf
Approved-Closed	GRI-DEN1-03	Policy/Contract/Fraternal Certificate	Dental Policy	Initial			AR policy 6-08.pdf
Approved-Closed	GRI-DEN1-OC-03	Outline of Coverage	Outline of coverage	Initial			AR OOC.pdf

Please Print
in blue Ink.

APPLICATION FOR [DENTAL/VISION] INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA

PROPOSED INSURED: _____ / / ❑ Male ❑ Female
First Name | Middle Initial | Last Name | Birth Date | Age | Gender

MAILING ADDRESS: _____
Street (Include Apt.)

City | State | [County] | ZIP

A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.

PHYSICAL ADDRESS: _____
Street (Include Apt.)

City | State | ZIP

PHONE NUMBERS: ( ) ( )
Home | Other | Best number and times to call | [E-mail Address]

DEPENDENTS: List below any dependents to be covered under the policy.

First Name	Relationship	Birth Date	Gender	First Name	Relationship	Birth Date	Gender
		/ /	❑M ❑F			/ /	❑M ❑F
		/ /	❑M ❑F			/ /	❑M ❑F
		/ /	❑M ❑F			/ /	❑M ❑F

PAYOR (If not You): _____
Name | [E-mail Address]

Street | City | State | ZIP

[1. Total Annual Household Income: ❑ $15,000 or less ❑ $15,001 to $35,000 ❑ $35,001 to $50,000 ❑ $50,001 to $75,000 ❑ $75,001 to $99,999 ❑ $100,000 or more]

	Yes	No
[2. Have you or has any applicant lived in the 50 states of the USA or the District of Columbia for **less than** the past [12] months? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)]	❑	❑
[3. If you are applying for dental insurance, do you or does any applicant now have dental insurance that **will not** terminate prior to the requested effective date? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)]	❑	❑
[4. If you are applying for vision insurance, do you or does any applicant now have vision insurance that **will not** terminate prior to the requested effective date? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)]	❑	❑

PLAN CHOICE: ❑ Plan 1 ❑ Plan 2 ❑ Plan 3

Optional Riders: ❑ Rider 1 ❑ Rider 2 ❑ Rider 3

REQUESTED EFFECTIVE DATE: ____/____/____
(See Statement of Understanding section.)

Payment Option: ❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule [at its Indianapolis or Lawrenceville office] with this application; (b) if other [dental/vision] insurance exists that duplicates coverage under the [dental/vision] plan being applied for, the existing [dental/vision] coverage must be terminated prior to the effective date of this coverage; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that, for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that, for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule [at its Indianapolis or Lawrenceville office]. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child

X _____
State where you signed this application

X _____
Date you signed and read application

X _____
Licensed Agent or Broker (Please print.)

X _____
Individual Producer Number

IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule [at its Indianapolis or Lawrenceville office] more than 15 days after the date signed. Altered applications will not be accepted.

GOLDEN RULE

Golden Rule Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

In this *policy*, "*you*" or "*your*" will refer to the Insured named on page 3, and "*we*," "*our*," or "*us*" will refer to Golden Rule Insurance Company [, a stock company].

Section 1

AGREEMENT AND CONSIDERATION

We will pay benefits for a *loss* as set forth in this *policy.* This *policy* is issued in exchange for and on the basis of the statements made on *your* application and payment of the first premium. It takes effect on the applicable *effective date* shown [on the Data Page.] It will remain in force until the first renewal date, and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where *you* live.

GUARANTEED RENEWABLE SUBJECT TO LISTED CONDITIONS

You may keep this *policy* in force by timely payment of the required premiums. However, *we* may refuse renewal if: (A) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (B) there is fraud or a material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

From time to time, *we* will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, age and sex of *covered persons,* type and level of benefits, time the *policy* has been in force, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. Premium rates are expected to increase over time.

At least a [31] day notice of any plan to take an action or make a change permitted by this clause will be mailed to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made by a *covered person* under this *policy*.

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this *policy.* If *you* are not satisfied, *you* may notify *us* within 10 days after *you* received it. Any premium paid will be refunded, less claims paid. This *policy* will then be void from its start.

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect application may cause *your policy* to be voided, or a claim to be reduced or denied.

This *policy* is signed for *us* as of the *effective date* as shown [on the Data Page.]

Secretary

Dental Insurance Policy

This policy is renewable, subject only to the two conditions set forth in the renewal clause. We have the right to change premiums as set forth above.

COPY OF APPLICATION ATTACHED

Table of Contents

Section	
[1	Policy Face Page
	Agreement and Consideration
	Guaranteed Renewable Subject to Listed Conditions
	10-Day Right to Examine and Return This Policy
2	Data Page
3	General Definitions
4	Premiums
5	Dependent Coverage
6	Continuing Eligibility
7	Amount Payable
8	Dental Benefits
9	Exclusions/Limitations
10	Reimbursement
11	Termination
12	Claims
13	The Contract]

Important Notice

This Policy is a legal contract between *you* and *us*.

READ *YOUR POLICY* CAREFULLY.

Section 2
DATA PAGE

[Policy Number - 999-999-999
Insured - John Doe
[**Plan [Choice]** – Option A/Option B]
[Total Premium - $XXXX.XX]]

[**Premium Mode-[**Monthly/Quarterly/semi-annually/annually]]
[**First Renewal Date -** Month Day, Year]
Effective Date:

[See rider-amendment(s) attached to policy]

IMPORTANT: *Non-preferred providers* may bill *you* for any amount up to the billed charge after *we* have paid benefits due under this *policy*. *Preferred providers* have agreed to discounted pricing for *covered expenses* with no additional billing to you other than coinsurance and *deductible amounts*.

[DENTAL BENEFIT

[Waiting Period][No Waiting Period]

[*Preventive services* ..... [[3] months]
[*Basic services* ..... [[6] months]
[*Major services* ..... [[12] months]

[**Deductible Amount] [per calendar year]**

[Individual ..... [[$50 [per calendar year]]]
[Individual *Non-preferred provider* ..... [[$50 [per calendar year]]]
[Family ..... [[$150 [per calendar year]]]
[Family *Non-preferred provider* ..... [[$150[per calendar year]]]
[Combined *Preventive, Basic and Major services* ..... [[$50[per calendar year]]]
[Combined *Preventive, Basic and Major services Non-preferred provider* [[$50[per calendar year]]]
[Lifetime ..... [[$200]]
[Lifetime *Non-preferred provider* ..... [[$200]]
[Family Deductible Limit ..... [[3] individual deductibles [per calendar year]]
[*Preventive services* ..... [[$0] per person[per calendar year]]
[*Preventive services Non-preferred provider* ..... [[$0] per person[per calendar year]]
[*Basic* and *Major* services ..... [[$50] per person[per calendar year]]
[*Basic* and *Major services Non-preferred provider* ..... [[$50 per person[per calendar year]]

[**Individual Maximum Benefit per Calendar Year** ..... [[$1000]]
[***Non-preferred provider*** **Individual Maximum Benefit per Calendar Year** ..... [[$1000]]
[First Year ..... [[$500]
Second Year ..... [$750]
Third Year and following years ..... [$1000]]

[Coinsurance [Percentage]]

[*Preventive services* ..... [[100%]]
[*Preventive services Non-preferred provider* ..... [[100%]]
[*Basic services* ..... [[80%]]
[*Basic services Non-preferred provider* ..... [[80%]]
[*Major services* ..... [[50%]]
[*Major services Non-preferred provider* ..... [[50%]]
[X-rays ..... [[Basic][100%]]]
[X-rays *Non-preferred provider* ..... [[Basic][100%]]]

Section 3
GENERAL DEFINITIONS

In this *policy, italicized* words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy:*

- *"Basic service"* includes [dental exams,] [X-rays,] [routine extractions,] [palliative treatment for dental pain,] and [simple restorative service (filling)].

- *"Coinsurance percentage"* means the percentage of *covered expenses* that are payable by *us.*

- *"Covered expense"* means a *dental service* that is:
  - (A) *Incurred* while the *covered person* is insured under this *policy*;
  - (B) Prescribed, ordered, recommended, authorized or approved for a *covered person* by a *dentist*;
  - (C) *Dentally necessary*;
  - (D) Covered by a specific benefit provision specified in this *policy*;
  - (E) Not excluded in the *policy*; and
  - (F) Allowed under all other applicable terms and conditions of the *policy*.

We will not pay benefits for that part of a *covered expense* which:

  - (A) Is subject to a *deductible amount* [or] coinsurance [or penalty];
  - (B) Exceeds any applicable benefit maximum;
  - (C) Exceeds the frequency limits described in the *policy*; or
  - (D) Is subject to a *waiting period.*

We will not pay benefits for that part of a *covered expense* which exceeds:

  - (A) The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option A]; or
  - (B) The *reasonable and customary charge* for that expense if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option B].

- *"Covered person"* means *you, your spouse* and each *eligible child*: (A) named in the application and not excluded by *us*; or (B) whom *we* agree in writing to add as a *covered person.*

- *"Deductible amount"* means the amount of *covered expenses* [, shown in the Data Page,] that must actually be paid by [*you*] [each *covered person]* during any calendar year before any benefits are payable.

[A new [deductible] must be met each calendar year.*]*

[The maximum number of *covered persons* in a family that must meet the [deductible] in a calendar year is shown in the Data Page.]

- *"Dental emergency"* means severe pain, swelling or bleeding of the teeth or supporting tissue which occurs as the direct result of unforeseen events or circumstances and in the judgment of a reasonable person, requires immediate care and treatment which is sought or received within 24 hours of onset.

- *"Dental service"* means any of the following services or items that are provided for dental care or treatment provided by a *Dentist* to the teeth or supporting tissue:
  - (A) Consultation, advice, diagnosis, surgery, visit, or referral;
  - (B) Procedure, treatment, or other care;
  - (C) Supply, equipment; or
  - (D) Drug or medicine.

However, if a *policy* section describes only certain services or items as *dental services*, then *we* will only pay benefits under that section for those services or items. In addition, we will not pay benefits for any *dental service* unless it satisfies the definition of a *covered expense*.

- *"Dentally necessary"* means necessary from a dental perspective, satisfying all of the following requirements:
  - (A) Does not, exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment to the *covered person*;
  - (B) Is known to be safe, effective and appropriate by most U.S. *dentists* with regard to accepted standards of dental practice at the time when the *dental service* is provided;
  - (C) Cannot be provided primarily for the comfort or convenience of a *covered person* or *dentist*;
  - (D) Cannot be omitted without an adverse effect;
  - (E) Is appropriate for the *covered person's* diagnosis or symptoms; and

(F) Is the most cost-effective treatment that is appropriate for the *covered person's* diagnosis. This means there is no other similar or alternate [appropriate] *dental service* [as determined by *us*] available at a lower cost.

A final decision to provide *dental services* can only be made by the *covered person* and his/her *dentist*. However, *we* will determine if a *dental service* is *dentally necessary* based on *our* consultation with an appropriate [*dentist*] [consultant].

To determine what is *dentally necessary, we* may require copies of dental records with information to support that treatment, level or frequency of treatment or that the appliance or device is consistent with the dental condition.

The fact that any particular *dentist* may prescribe, order, recommend, or approve a treatment, test, or procedure does not, of itself, make the treatment, test, or procedure, *dentally necessary*. A determination of what is *dentally necessary* does not constitute a dental treatment decision.

• *"Dentist"* means a legally licensed dentist practicing within the scope of the license and currently licensed by the state in which the services are provided. *Dentist* also includes:

(A) A legally licensed oral surgeon, endodontist, periodontist, prosthodontist and pedodontist, practicing within the scope of his or her license; and

(B) A legally licensed dental hygienist practicing within the scope of the license while under the supervision of a *dentist*.

A *dentist* cannot be a family member of a *covered person*.

• *"Dependent"* means *your spouse* and/or an *eligible child*.

• *["Doctor"* means a duly licensed practitioner of the medical arts, limited to a physician holding an M.D. or D.O. degree. With regard to medical services provided to a *covered person*, a *doctor* must be currently licensed by the state in which the services are provided, and the services must be provided within the scope of that license. With regard to consulting services provided to *us*, a *doctor* must be currently licensed by the state in which the consulting services are provided.*]*

• *"Effective date"* means the [applicable] date a *covered person* becomes insured under this *policy*. The [applicable] *effective date* is shown: (A) [in the Data Page] of this *policy* for initial *covered persons*; and (B) on the rider adding any new *covered person*.

• *"Eligible child"* means *your* or *your dependent's* child, if that child is: (A) not married; and (B) under 26 years of age.

As used in this definition, "child" means: (A) a natural child; (B) a legally adopted child; (C) a child placed with *you* for adoption; or (D) a child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

• *"Emergency palliative treatment"* means necessary procedures for the initial treatment of a *dental emergency*. This treatment does not include periodontal treatment or any *dental service* to restore or replace a tooth.

• *"Incurred"* means that a *dental service* has been provided to a *covered person* and a fee or charge is owed to the *dentist* for the service. *Covered expenses* for *dental services* will be considered to be *incurred* for:

(A) Appliances or a modification of appliances on the date the master impression is made;

(B) A crown, a bridge, a veneer or inlay or onlay restoration on the date the tooth or teeth are prepared;

(C) Root canal therapy on the date the pulp chamber is opened; and

(D) All other charges on the date the *dental service* is rendered or a supply furnished.

• *"Investigational treatment"* means a treatment that *we* determine meets one or more of the following criteria after consultation with a medical professional:

(A) The procedure, service, or supply is under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

(B) The procedure, service, or supply has not been determined through prevailing peer-reviewed medical literature to be safe and effective for the proposed use.

(C) In the case of a drug, device, or other supply that is subject to *USFDA* approval:

(1) It does not have *USFDA* approval;

(2) It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

(3) It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be: (a) included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or (b) safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications.

(D) The provider's research protocols indicate that the procedure, service, or supply is investigational or experimental.

Items (C) and (D) above do not apply to phase III or IV *USFDA* clinical trials.

- *"Loss"* means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

- *"Major service"* includes [endodontics,] [periodontics,] [major restorative services (crowns, inlays, onlays and veneers),] [prosthetics (bridges and dentures),][or][oral surgery for impactions,].

- *["Network"* means a *preferred provider* organization comprised of a group of *dentists* that contract with *us* to provide services covered by this plan at a contracted rate.]

- *["Non-preferred provider"* means a *dentist* who has not agreed with a *network* to provide *dental services* at the contracted rate.]

- *["Out-of-pocket expenses" means those expenses that a covered person is required to pay that qualify as covered expenses;]*

- *"Policy"* when *italicized*, means this policy issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

- *["Preferred provider"* means a *dentist* who has agreed with a *network* to provide *dental services* at the contracted rate and who is identified in the most current list of *preferred providers* for the *network* shown on [the front of] *your* dental identification card.]

- *"Preventive service"* includes [dental exams,] [X-rays,] [prophylactic cleaning,] [fluoride treatment,] [sealants,] and [space maintainers].

- *"Proof of loss"* means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, dental bills or records, other plan information, and network repricing information. [*Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.]

- *"Reasonable and customary charge"* means, with respect to fees charged, a fee calculated by *us* based on available data resources [(Ingenix Survey of Dental Charges)] of competitive fees in that geographic area. A fee will not be a *reasonable and customary charge* if it exceeds what the provider would charge any similarly situated payor for the same services. If a provider routinely waives [coinsurance and/or] the annual deductible for benefits, the fee for the dental *services* for which the [[coinsurance] and/or [the annual deductible]] are waived will not be a *reasonable and customary charge*.

Reasonable and customary charges are determined solely in accordance with *our* reimbursement policy guidelines. The reimbursement policy guidelines are developed by *us*, at *our* discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

(A) As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);

(B) As reported by generally recognized professionals or publications;

(C) As utilized for Medicare;

(D) As determined by medical or dental staff and outside medical or dental consultants;

(E) Pursuant to any other appropriate source or determination accepted by *us*.

- *"Residence"* means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* home address will be deemed to be *your residence*. If *you* do not file a United States income tax return, the location where *you* spend the greatest amount of time will be deemed to be *your residence*.

- *"Spouse"* means your lawful wife or husband.

- *"Waiting Period"* means a period of time for which a *covered person* must wait, after the *effective date* of coverage, before *dental services* listed in [Section 8: Dental Benefits] will be covered.

Section 4
PREMIUMS

PREMIUM PAYMENT: Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

GRACE PERIOD: *You* have until the 31st day following each premium due date to pay all premiums due. *We* may pay benefits for *your covered expenses incurred* during this 31-day grace period. Any such benefit payment is made in reliance on the receipt of the full premium due from *you* by the end of the grace period.

However, if *we* pay benefits for any claims during the grace period, and the full premium is not paid by the end of the grace period, *we* will require repayment of all benefits paid from *you* or any other person or organization that received payment on those claims. If repayment is due from another person or organization, *you* agree to assist and cooperate with *us* in obtaining repayment. *You* are responsible for repaying *us* if we are unsuccessful in recovering *our* benefits from these other sources.

[MISSTATEMENT OF AGE OR SEX: If a *covered person's* age or sex has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age or sex.]

[CHANGE OR MISSTATEMENT OF RESIDENCE: If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. [*Your* premium will be based on *your* new *residence* beginning on the first premium due date after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first premium due date *you* resided at that *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.]]

BILLING/ADMINISTRATIVE FEES: Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a [$20] fee for any check or automatic payment deduction that is returned unpaid.

Section 5
DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY: *Your dependents* become eligible for insurance on the later of: (A) the date *you* became insured under this *policy;* or (B) [the first day of the premium period after] the date of becoming *your dependent.*

EFFECTIVE DATE FOR INITIAL DEPENDENTS: The *effective date* for *your* initial *dependents,* if any, is shown [on the Data Page.] Only *dependents* for whom application has been made and approved by *us* will be covered on *your effective date.*

ADDING A NEWBORN CHILD: An *eligible child* born to or adopted within 90 days of birth by *you* or a *covered person* will be covered from the time of birth until [the 91st day] after birth.

Additional premium may be required to continue coverage beyond [the 91 st day] after the date of birth or adoption of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on [the 91st day] after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) any required premium within [90 days] of the child's birth.

ADDING OTHER DEPENDENTS: If: (A) *you* apply in writing for insurance on a *dependent*; (B) *you* pay the required premiums; and (C) *we* agree to insure the *dependent*; then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

Section 6
CONTINUING ELIGIBILITY

[For All Covered Persons: A *covered person's* eligibility for insurance under this *policy*] will cease on the earlier of:

(A) The date that a *covered person* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer for any portion of the premium for coverage under this *policy*; or

(B) The date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.]

[For Dependents: A *dependent* will cease to be a *covered person* at the end of the *premium period* in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child.*

We must receive notification within 90 days of the date a *covered person* ceases to be a *dependent.* If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the *policy* month in which *we* receive the notice.

For Eligible Children:
A *covered person* will not cease to be an *eligible child* solely because of age if the *covered person* is: (A) not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and (B) mainly dependent on *you* for support.]

We may ask for proof of the *eligible child's* incapacity or dependency two months before the date the *dependent* would otherwise cease to be covered. *We* may require the same proof again, but *we* will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earliest of:

(A) The date the *policy* ends.

(B) The date all coverage for *you* and *your dependents* ends.

(C) The date the incapacity or dependency ends.

(D) The last due date of any premium period for which premium was paid, if premium for the subsequent premium period is not paid when due.

A child will cease as a *covered person* as of the date a *covered expense* is *incurred* if, as part of the required *proof of loss* we ask for proof of the child's status and *you* fail to provide proof that as of the date the expense was incurred the child remained:

(A) Unable to engage in self-sustaining employment due to mental incapacity or physical handicap; and

(B) Financially dependent on *you*.

Section 7
AMOUNT PAYABLE

AMOUNT PAYABLE: *We* will pay the applicable *coinsurance percentage* in excess of the applicable *deductible amount* for the actual cost of services and supplies that:

(A) Qualify as *covered expenses* under each benefit provision; and

(B) Are received while the *covered person's* insurance is in force under this *policy*.

[The total amount payable for each *covered person* under this *policy* will not exceed the maximum benefit limit shown [in the Data Page.]]

INDIVIDUAL AND FAMILY DEDUCTIBLES:
[*You* and/or *your* covered *dependent* may have to pay an individual *deductible amount* before *we* pay any benefits. The *deductible amount* may apply per calendar year or per lifetime [as shown in the Data Page].]

[We may limit the number of deductibles for *you* and *your* covered *dependents* to a specific number of deductibles [as shown in the Data Page].]

CALENDAR YEAR MAXIMUM: The total amount *we* will pay [for certain types of *dental services,]* under this *policy,* may be limited to a yearly maximum [as shown in the Data Page]. The maximum applies each calendar year.

WAITING PERIOD: Benefits for certain types of *dental services* will not be payable until after a *waiting period* [as shown in the Data Page] has been satisfied.

COVERAGE UNDER OTHER POLICY PROVISIONS: Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy*.

[PREDETERMINATION: If the total cost for a dental treatment plan is expected to be [$300] or more, we strongly encourage *you* or *your* covered *dependent* or the *dentist* to request a predetermination from *us*. The request must include information about the treatment plan. *We* will tell the *dentist* what benefit amount *we* expect to pay, subject to the Alternate Procedures section.]

[Our estimate is valid for [180] days from the date *we* provide it to the *dentist,* as long as *your* or *your* covered *dependent's* insurance is in force when the *dental service* is *incurred.* If *you* or *your* covered *dependent* will not receive the *dental services* within the [180] days, *you* or *your* covered *dependent* or the *dentist* must request another predetermination from *us*. *Dental services* must be *incurred* while *you or your* covered *dependents* are insured by the plan.]

ALTERNATE PROCEDURES: If two or more services are considered to be acceptable to correct the same dental condition, the amount payable will be based on the *covered expenses* for the least expensive service that will produce a professionally satisfactory result as determined by *us* or *our* representatives.

If *you* decide or *your dentist* decides on a more costly treatment than *we* have determined to be satisfactory for treatment of the condition, payment will be subject to any applicable deductible amount and *coinsurance percentage* and will be limited to:

(A) The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option A]; or

(B) The *reasonable and customary charge* for that expense if [Section 2, Data Page, of this policy] identifies [your plan choice as Option B.

Section 8
DENTAL BENEFITS

DENTAL BENEFITS Benefits are limited to the *dental services* described below, per *covered person*, but only when each service is a *covered expense*:

(A) Oral evaluations (periodic, comprehensive and problem-focused) payable twice in any calendar year;

(B) Prophylaxis or cleaning teeth, payable twice in any calendar year;

(C) Topical fluoride for a *covered person* who is not yet age [16], payable twice in any calendar year. Topical fluoride treatment should be done in conjunction with dental prophylaxis;

(D) Full mouth (which includes bitewings) or panorex X-rays, payable once every [36] months. An exception will be made to the [36]-month limit if the full mouth or panorex X-rays are for diagnosis of third molars, cysts, or neoplasm;

(E) Up to four bitewing X-rays, payable [once] in any calendar year;

(F) Periapical X-rays;

(G) Sealants or preventive resin restorations, limited to once per first or second permanent molar every [36] consecutive months, for a *covered person* who is not yet age [16];

(H) Simple (nonsurgical) extractions;

(I) Injection of antibiotic drugs at the time of initial treatment;

(J) Palliative treatment when no other service, other than X-rays and exam, was done on the same tooth during the same visit;

(K) *Emergency palliative treatment* for dental pain;

(L) Amalgam fillings and direct resin fillings. Multiple restorations on one surface will be treated as a single filling;

(M) Analgesia, for a *covered person* who is not yet age [13];

(N) Sedative fillings as a separate benefit when no other service, other than X-rays and exam, was done on the same tooth during the same visit;

(O) Stainless steel crowns on primary teeth;

(P) Space maintainers to maintain space because of prematurely lost primary teeth, including the cost of recementing limited to once per lifetime, for a *covered person* who is not yet age [16]. This includes all adjustments within [6] months of installation;

(Q) Repair or recementing of crowns, inlays, onlays, veneers, bridgework, or dentures, relines and rebases, but not within [6] months of the initial placement and not more than once in any [12]-month period;

(R) Endodontic treatment, including root canals, pulpotomies on primary teeth and apicoectomy. To be a *covered expense*, pulpotomies performed on permanent teeth must be combined with the completed root canal;

(S) Periodontics, including procedures necessary for treatment of disease of the gums and bone-supporting teeth. Periodontal maintenance and gingival inflammation cleaning procedures are covered as routine prophylaxis benefits under *preventive services* if no active therapy has been performed. Active periodontal therapy means periodontal surgical or nonsurgical treatment.

Periodontal maintenance procedures are payable [twice] in any calendar year. Periodontal root planing and scaling is payable every [24]-month period, limited to four quadrants. Full mouth debridement is limited to [once] every [36] consecutive months.

The benefit for periodontal surgery includes three months of post-surgical care. Any periodontal surgery performed in the same quadrant within [36] consecutive months after the initial surgery was performed is not payable. If more than one surgical service is performed on the same day, only the most inclusive surgical service performed will be considered a *covered expense*;

(T) Osseous grafts with or without restorable or nonrestorable GTR membrane replacement are limited to once every consecutive [36] months per quadrant or surgical site;

(U) Pin retention, limited to [2] pins per tooth; this is not a *covered expense* if pin retention is in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays);

(V) Inlays, onlays, or veneers limited to one time per [60] consecutive months;

(W) Core buildup, cast and prefabricated post and core. Posts and cores are *covered expenses* only for teeth that have had a root canal therapy;

(X) First installation of bridgework to replace one or more functioning natural teeth lost while *you* or *your* covered *dependents* are insured by this plan. This includes inlays and crowns as abutments;

(Y) Full or partial dentures or overdentures, payable once every [5] years. The amount *we* will pay for overdentures will not exceed the benefit *we* would pay for full dentures;

(Z) Oral surgery, including surgical extractions and removal of impacted teeth. Charges for diagnostic xrays must be included in the charges for oral surgery to be *covered expenses*; and

(AA) General anesthesia, but only:

(1) For removal of impacted teeth;

(2) For removal of [seven] or more teeth; or

(3) If *dentally necessary* in conjunction with complex oral surgery.

For all *covered expenses*, the following *dental services* will be considered part of the entire *dental service* and not eligible for benefits as a separate service: cement bases; pulp caps; study models/diagnostic casts; acid etch; bonding agents; and local anesthetic.

Section 9
GENERAL EXCLUSIONS/LIMITATIONS

No benefits will be paid for any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services which are not *covered expenses.*

Covered expenses will not include, and no benefits will be paid for any charges that are incurred for:

(A) Any expense or service related to that expense:

(1) That is not a *covered expense*;

(2) *Incurred* during the *waiting period*;

(3) To the extent that expense exceeds:

a. The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option A]; or

b. The *reasonable and customary charge* for that expense, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option B].

(4) For which no benefit is described in the *policy* or [in the Data Page];

(5) For a *dental service* that is not rendered or that is not rendered within the scope of the *dentist's* license;

(6) For *dental services*, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under the Dental Benefits provision of this *policy*;

(7) Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service;

(8) For telephone consultations or for failure to keep a scheduled appointment;

(9) [For any *dental service* incurred directly or indirectly as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*;]

(10) For or while receiving *investigational treatment* or for complications there from, including expenses that might otherwise be covered if they were not *incurred* in conjunction with, as a result of, or while receiving *investigational treatment;*

(11) As a result of *dental services* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law; [or]

(12) As a result of:

a. Intentionally self-inflicted bodily harm (whether the *covered person* is sane or insane);

b. *Dental services* necessitated due to any act of declared or undeclared war;

c. The *covered person* taking part in a riot; [or]

d. The *covered person's* commission of a felony, whether or not charged.

(B) Any *dental service*:

(1) Provided by a government plan, program, hospital or other facility, unless by law *you* or *your* covered *dependent* must pay and it is otherwise a *covered expense;*

(2) Which by law must be provided by an educational institution;

(3) Which would be free of charge without this insurance, unless provided by Medicaid or by the Veterans Administration for non-service related *dental services* and which by law *we* are required to pay;

(4) Provided by a family member or by someone who ordinarily resides with *you* or *your* covered *dependent*;

(5) Provided prior to the *effective date* or after the termination date of this policy;

(6) Received outside of the United States, except for a *dental emergency*;

(7) For jaw-joint problems, including but not limited to: temporomandibular or craniomandibular joint dysfunction, myofunctional therapy, physical therapy;

(8) Relating to: teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by *us*;

(9) That is considered cosmetic dentistry, including, but not limited to: porcelain on a crown, abutment or pontics posterior to the second bicuspid; personalization or characterization of prosthetic devices; or composite restorations on molar and/or bicuspid teeth. Alternate services will be applied allowing benefits for amalgam restoration; bleaching; and services done to alter the shape or size of teeth. (Cosmetic services are those services that improve physical appearance);

(C) Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction;

(D) Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation;

(E) Orthognathic surgery to correct malposition of jaw bones;

(F) Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue;

(G) Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal;

(H) Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function;

(I) Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; replacement of orthodontic retainers; treatment splints; bruxism appliance; sleep disorder appliance; and gold foil restorations;

(J) Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; prescription and non-prescriptions drugs, with or without a prescription, unless they are dispensed and utilized in the dental office during *your* or *your* covered *dependents'* dental visit, except *we* will pay for injection of antibiotic drugs at the time of initial treatment; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures;

(K) Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are:

(1) Congenitally missing; or

(2) Lost before insurance under this *policy* is in effect.

However, benefits are available for *covered expenses* for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first [6] months following the date of placement, only if:

(1) The teeth were lost while the *covered person* was under the *policy* and the initial placement is within [12] months of the date of loss of the teeth; or

(2) The extraction took place while the *covered person* was both under age [16] and insured under this *policy*.

(L) Replacement within [60] consecutive months of the last placement for full and partial dentures and replacement within [60] consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within [12] months from the date the temporary service was installed;

(M) Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances inserted prior to plan coverage unless the *covered person*

has been insured under the plan for [12] continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this [12]-month period, *dental services* associated with the addition will be covered when the service is a *covered expense*;

(N) Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the *Dentist*. If replacement is necessary because of *your* or *your dependents'* non-compliance, *you* are liable for the cost of the replacement;

(O) Dental implants and any related procedures, including but not limited to crowns, bridges, and dentures;

(P) Hospital or other facility charges and related anesthesia charges;

(Q) Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis;

(R) Local anesthetic; analgesia; and behavior management and conscious sedation;

(S) Charges for *dental services* that are not documented in the *dentist* records, not directly associated with dental disease or not performed in a dental setting ;

(T) Orthodontia;

(U) Acupuncture; acupressure and other forms of alternative treatment;

(V) Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations); or

(W) [Any *dental services* for which benefits are payable under a medical *policy* issued by *us*.]

EXCLUSION ON CHARGES IN EXCESS OF REASONABLE AND CUSTOMARY: If a charge *incurred* by *you* or *your* covered *dependent* for services or supplies is in excess of the *reasonable and customary charge,* no payment will be made with respect to the excess amount of the charge. That part of the charge that is in excess of the *reasonable and customary charge* will not qualify as a *covered expense* under this *policy.*

Section 10
REIMBURSEMENT

If a *covered person's dental services* are caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*. However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *dental services* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

(A) To fully cooperate with *us* in order to obtain information about the *loss* and its cause;

(B) To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;

(C) To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;

(D) That *we*:

(1) Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid;

(2) May give notice of that lien to any *third party* or *third party's* agent or representative;

(3) Will have the right to intervene in any suit or legal action to protect *our* rights;

(4) Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf;

(5) May assert that subrogation right independently of the *covered person.*

(E) To take no action that prejudices *our* reimbursement and subrogation rights;

(F) To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights;

(G) To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so;

(H) To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *dental services*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses;

(I) That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian (if the *covered person* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *covered person* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *covered person's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount a *covered person* must reimburse *us*, the *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

Definition: As used in this provision, the following term has the meaning indicated:

"Third party" means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *dental services*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Section 11
TERMINATION

TERMINATION OF POLICY: All insurance will cease on termination of this *policy.* This *policy* will terminate on the earliest of:

(A) Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;

(B) The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request;

(C) The date *we* decline to renew this *policy,* as stated [in the Guaranteed Renewable provision];

(D) The date of *your* death, if no *dependents* are covered under this plan;

(E) [The date that a *covered person* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;]

(F) The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in [the Continuing Eligibility section in this *policy*].

We will refund any premium paid and not earned due to *policy* termination.

If this *policy* includes *dependents*, it may be continued after *your* death: (A) by *your spouse*, if a *covered person;* otherwise, (B) by the youngest child who is a *covered person.*

This *policy* will be changed to a plan appropriate, as determined by *us,* to the *covered person(s)* that continues to be covered under it. *Your spouse* or youngest child will replace *you* as the insured. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

DENTAL CLAIMS INCURRED PRIOR TO A TERMINATION DATE: Termination of insurance or termination of a benefit will not apply to a valid claim for benefits *incurred* before the termination date.

REINSTATEMENT: If *your policy* lapses due to nonpayment of premium, it may be reinstated, upon payment of a [$50] reinstatement fee, provided:

(A) *We* receive from *you* a written application for reinstatement accompanied by the required reinstatement fee and premium payment within 60 days after the date coverage lapsed; and

(B) *We* approve the application in writing.

Premium required and accepted for reinstatement will be applied to the period for which premium had not been paid.

If *we* would not agree to insure *you* if *you* were applying initially for this *policy*, we will not reinstate coverage.

Section 12
CLAIMS

CLAIM FORMS: *We* will furnish claim forms after *we* receive notice of a claim. If *our* usual claim forms are not furnished within 15 days, *you* or *your* covered *dependent* may file a claim without them. The claim must contain written *proof of loss.*

NOTICE OF CLAIM: *We* must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

PROOF OF LOSS: *You* or *your* covered *dependent* must give *us* written *proof of loss* within [90 days] of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than [one year late] will not be accepted, unless *you* or *your* covered *dependent* had no legal capacity in that year.

COOPERATION PROVISION: Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

(A) Sign, date and deliver to *us* authorizations to obtain any dental, medical or other information, records or documents *we* deem relevant from any person or entity;

(B) Obtain and furnish to *us*, or *our* representatives, any dental, medical or other information, records or documents *we* deem relevant;

(C) Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask;

(D) Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our representative*, any information, records or documents requested by *us*).

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

TIME FOR PAYMENT OF CLAIMS: Benefits will be paid as soon as *we* receive proper *proof of loss*.

PAYMENT OF CLAIMS: Except as set forth in this provision, all benefits are payable to *you*. Any accrued benefits unpaid at *your* death or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a *beneficiary* who is a minor or is otherwise not competent to give valid release, *we* may pay up to [$1,000] to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *dental services*, directly to the *dentist* or other person providing such services, unless *you* provide other written direction no later than the time of filing *proof of loss*.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. [*We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.]

FOREIGN CLAIMS INCURRED FOR DENTAL EMERGENCY CARE: Claims *incurred* outside of the United States for *dental emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical or dental records in English to show proper *proof of loss.*

MEDICAID REIMBURSEMENT: The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if: (A) a *covered person* is eligible for coverage under his or her state's Medicaid program; and (B) *we* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

CUSTODIAL PARENT: This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the noncustodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

(A) Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;

(B) Accept claim forms and requests for claim payment from the custodial parent; and

(C) Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *dentist* providing treatment to an *eligible child*.

DENTAL EXAM: At *our* expense, *we* have the authority to require *you* or *your* covered *dependent* to have a dental exam with a *dentist* at any time regarding a claim for benefits.

LEGAL ACTIONS: No suit may be brought by *you* on a claim sooner than [60 days] after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in [the complaint/grievance procedures made available to resolve disputes in *your* state of *residence* under *your policy*]. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date [*we* notified *you* of the final decision on *your* complaint/grievance].

[HEALTH INSURANCE FOR DENTAL SERVICES: If any *covered expenses* under this *policy* are also payable under health insurance or other health coverage, *we* will not make payment under this dental *policy* until after *we* determine what benefits are paid or payable by the health insurance or other health coverage plan.

Our payment under this *policy* will be reduced by the amount of any benefits that are payable for a *covered person* by any other dental or health plan.

[Your out-of-pocket expenses for dental benefits will not apply to *your out-of-pocket expenses* for medical benefits.]]

PROVIDER DISCOUNTS: *We* may have established an arrangement with certain *dentists* to offer a discount on services rendered. For the purposes of this provision, discount means any negotiated reduction or variation from the schedule of billed charges that a *dentist* otherwise would require a patient and/or *us* to pay to that *dentist*.

Section 13
THE CONTRACT

CONTRACT: This *policy,* with the application and any rider-amendments is the entire contract between *you* and *us*. No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy.* No agent may: (A) change this *policy*; (B) waive any of the provisions of this *policy*; (C) extend the time for payment of premiums; or (D) waive any of *our* rights or requirements.

NON-WAIVER: If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

TIME LIMIT ON CERTAIN DEFENSES: A misstatement by *you* in any application for this *policy* may be used to void this *policy* or to deny a claim. This action may be taken in the first two years, with no lapse, of a person's coverage. After the two-year period, this action may be taken only for a fraudulent misstatement.

REPAYMENT FOR FRAUD, MISREPRESENTATION OR FALSE INFORMATION: During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy.*

CONFORMITY WITH STATE LAWS: Any part of this *policy* in conflict with the laws of the state where *you* live on this *policy's effective date* is changed to conform to the minimum requirements of that state's laws.

CONDITIONS PRIOR TO LEGAL ACTION: On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must: (A) identify the coverage, benefit, premium, or other disagreement; (B) refer to the specific *policy* provision(s) at issue; and (C) include all relevant facts and information that support *your* position. Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within [30 days] after *we* receive *your* notice of intention to sue *us*.

Golden Rule Insurance Company

Golden Rule Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

In this outline, "you" or "your" will refer to the person for whom this outline has been prepared, and "we," "our," or "us" will refer to Golden Rule Insurance Company.

LIMITED BENEFIT HEALTH COVERAGE
[Dental Coverage]
Outline of Coverage for Policy Form [GRI-DEN1-03]
(Please retain this outline for your records)

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail *your* and *our* rights and obligations. For this reason, It is important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Health Coverage – Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

[Dental Coverage – Plans of this type are designed to provide the covered persons with coverage for dental care. The cost must be due to a covered dental service. Coverage is provided for preventive, basic, and major dental services. Coverage is subject to any deductible amounts, coinsurance amounts, or other limitations that may be set forth in the policy.]

Dental Benefits

DENTAL BENEFITS Benefits are limited to the *dental services* described below, but only when each service is a *covered expense*:

(A) Oral evaluations (periodic, comprehensive and problem focused) payable twice in any calendar year;

(B) Prophylaxis or cleaning teeth, payable twice in any calendar year;

(C) Topical fluoride for a *covered person* who is not yet age [16], payable twice in any calendar year. Topical fluoride treatment should be done in conjunction with dental prophylaxis;

(D) Full mouth (which includes bitewings) or panorex xrays, payable once every [36] months. An exception will be made to the [36] month limit if the full mouth or panorex xrays are for diagnosis of third molars, cysts, or neoplasm;

(E) Up to four bitewing xrays, payable [once] in any calendar year;

(F) Periapical xrays;

(G) Sealants or preventive resin restorations, limited to once per first or second permanent molar every [36] consecutive months, for a *covered person* who is not yet age [16];

(H) Simple (non-surgical) extractions;

(I) Injection of antibiotic drugs at the time of initial treatment;

(J) Palliative treatment when no other service, other than xrays and exam, was done on the same tooth during the same visit;

(K) *Emergency palliative treatment* for dental pain;

(L) Amalgam fillings and direct resin fillings. Multiple restorations on one surface will be treated as a single filling;

(M) Analgesia, for a *covered person* who is not yet age [13];

(N) Sedative fillings as a separate benefit when no other service, other than xrays and exam, was done on the same tooth during the same visit;

(O) Stainless steel crowns on primary teeth;

(P) Space maintainers to maintain space because of prematurely lost primary teeth, including the cost of recementing limited to once per lifetime, for a *covered person* who is not yet age [13]. This includes all adjustments within [6] months of installation;

(Q) Repair or recementing of crowns, inlays, onlays, veneers, bridgework, or dentures, relines and rebases, but not within [6] months of the initial placement and not more than once in any [12] month period;

(R) Endodontic treatment, including root canals, pulpotomies on primary teeth and apicoectomy. To be a *covered expense*, pulpotomies performed on permanent teeth must be combined with the completed root canal;

(S) Periodontics, including procedures necessary for treatment of disease of the gums and bone supporting teeth.

Periodontal maintenance and gingival inflammation cleaning procedures are covered as routine prophylaxis benefits under *preventive services* if no active therapy has been performed. Active periodontal therapy means periodontal surgical or non-surgical treatment.

Periodontal maintenance procedures are payable [twice] in any calendar year. Periodontal root planing and scaling is payable every [24] month period, limited to four quadrants. Full mouth debridement is limited to [once] every [36] consecutive months.

The benefit for periodontal surgery includes three months of post-surgical care. Any periodontal surgery performed in the same quadrant within [36] consecutive months after the initial surgery was performed is not payable. If more than one surgical service is performed on the same day, only the most inclusive surgical service performed will be considered a *covered expense*;

(T) Osseous grafts with or without restorable or non-restorable GTR membrane replacement are limited to once every consecutive [36] months per quadrant or surgical site;

(U) Pin retention, limited to [2] pins per tooth; this is not a *covered expense* if pin retention is in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays.);

(V) Inlays, onlays, or veneers limited to one time per [60] consecutive months;

(W) Core buildup, cast and prefabricated post and core. Posts and cores are *covered expenses* only for teeth that have had a root canal therapy;

(X) First installation of bridgework to replace one or more functioning natural teeth lost while *you* or *your* covered *dependents* are insured by this plan. This includes inlays and crowns as abutments;

(Y) Full or partial dentures or overdentures, payable once every [5] years. The amount *we* will pay for overdentures will not exceed the benefit *we* would pay for full dentures;

(Z) Oral surgery, including surgical extractions and removal of impacted teeth. Charges for diagnostic xrays must be included in the charges for oral surgery to be *covered expenses*; and

(AA) General anesthesia, but only:

For removal of impacted teeth;

(1) For removal of [seven] or more teeth; or

(2) If *dentally necessary* in conjunction with complex oral surgery.

For all *covered expenses*, the following *dental services* will be considered part of the entire *dental service* and not eligible for benefits as a separate service: cement bases; pulp caps; study models/diagnostic casts; acid etch; bonding agents; and local anesthetic.

Amount Payable

We will pay the coinsurance percentage in excess of the deductible amount for services and supplies that qualify as covered expenses and are received while the covered person's coverage is in force under the policy.

The Deductible Amount: "Deductible amount" means the amount of covered expenses [shown in the Data Page[that must be actually paid by [you] [each covered person] during any calendar year before any benefits are payable.

[A new [deductible] must be met each calendar year.]

Coinsurance Percentage: Coinsurance percentage" means the percentage of covered expenses that are payable by us.

"Out-of-pocket expenses" means those expenses that a covered person is required to pay that qualify as covered expenses and are not paid or payable if a claim were made under any other plan.

Maximum Benefit: The maximum benefit per covered person, per calendar year is [shown in the policy Data Page].

WAITING PERIOD: "*Waiting Period*" *means a period of time for which a* covered person *must wait, after the* effective date *of coverage, before* dental services *listed in [Section 8: Dental Benefits] will be covered.*

Benefits for certain types of *dental services* will not be payable until after a *waiting period* [as shown in the Data Page] has been satisfied.

What Is Not Covered

No benefits will be paid for any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services which are not *covered expenses.*

Covered expenses will not include, and no benefits will be paid for any charges that are incurred for:

(A) Any expense or service related to that expense:

(1) That is not a *covered expense*;

(2) *Incurred* during the *waiting period*;

(3) To the extent that expense exceeds:

a. The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option A]; or

b. The *reasonable and customary charge* for that expense, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option B].

(4) For which no benefit is described in the *policy* or [in the Data Page];

(5) For a *dental service* that is not rendered or that is not rendered within the scope of the *dentist's* license;

(6) For *dental services*, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under the Dental Benefits provision of this *policy*;

(7) Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service;

(8) For telephone consultations or for failure to keep a scheduled appointment;

(9) [For any *dental service* incurred directly or indirectly as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*;]

(10) For or while receiving *investigational treatment* or for complications there from, including expenses that might otherwise be covered if they were not *incurred* in conjunction with, as a result of, or while receiving *investigational treatment;*

(11) As a result of *dental services* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law; [or]

(12) As a result of:

a. Intentionally self-inflicted bodily harm (whether the *covered person* is sane or insane)

b. *Dental services* necessitated due to any act of declared or undeclared war;

c. The *covered person* taking part in a riot; [or]

d. The *covered person's* commission of a felony, whether or not charged.

(B) Any *dental service*:

(1) Provided by a government plan, program, hospital or other facility, unless by law *you* or *your* covered *dependent* must pay and it is otherwise a *covered expense;*

(2) Which by law must be provided by an educational institution;

(3) Which would be free of charge without this insurance, unless provided by Medicaid or by the Veteran's Administration for non-service related *dental services* and which by law *we* are required to pay;

(4) Provided by a family member or by someone who ordinarily resides with *you* or *your* covered *dependent*;

(5) Provided prior to the *effective date* or after the termination date of this policy;

(6) Received outside of the United States, except for a *dental emergency*;

(7) For jaw-joint problems, including but not limited to: temporomandibular or craniomandibular joint dysfunction, myofunctional therapy, physical therapy;

(8) Relating to: teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by *us*;

(9) That is considered cosmetic dentistry, including, but not limited to: porcelain on a crown, abutment or pontics posterior to the second bicuspid; personalization or characterization of prosthetic devices; or composite restorations on molar and/or bicuspid

teeth. Alternate services will be applied allowing benefits for amalgam restoration; bleaching; and services done to alter the shape or size of teeth. (Cosmetic services are those services that improve physical appearance);

(C) Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction;

(D) Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation;

(E) Orthognathic surgery to correct malposition of jaw bones;

(F) Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue;

(G) Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal;

(H) Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function;

(I) Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; replacement of orthodontic retainers; treatment splints; bruxism appliance; sleep disorder appliance; and gold foil restorations;

(J) Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; prescription and non-prescriptions drugs, with or without a prescription, unless they are dispensed and utilized in the dental office during *your* or *your* covered *dependents* dental visit, except *we* will pay for injection of antibiotic drugs at the time of initial treatment; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures;

(K) Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are:

(1) Congenitally missing; or

(2) Lost before insurance under this *policy* is in effect;

However, benefits are available for *covered expenses* for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first [6] months following the date of placement, only if:

(1) The teeth were lost while the *covered person* was under the *policy* and the initial placement is within [12] months of the date of loss of the teeth; or

(2) The extraction took place while the *covered person* was both under age [16] and insured under this *policy*;

(L) Replacement within [60] consecutive months of the last placement for full and partial dentures and replacement within [72] consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within [12] months from the date the temporary service was installed;

(M) Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances inserted prior to plan coverage unless the *covered person* has been insured under the plan for [12] continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this [12] month period, *dental services* associated with the addition will be covered when the service is a *covered expense*;

(N) Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the *Dentist*. If replacement is necessary because of *your* or *your dependents'* non-compliance, *you* are liable for the cost of the replacement;

(O) Dental implants and any related procedures, including but not limited to crowns, bridges, and dentures;

(P) Hospital or other facility charges and related anesthesia charges;

(Q) Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis;

(R) Local anesthetic; analgesia; and behavior management and conscious sedation;

(S) Charges for *dental services* that are not documented in the *dentist* records, not directly associated with dental disease or not performed in a dental setting ;

(T) Orthodontia;

(U) Acupuncture; acupressure and other forms of alternative treatment;

(V) Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations); or

[Any *dental services* for which benefits are payable under a medical *policy* issued by *us*.]

[EXCLUSION ON CHARGES IN EXCESS OF REASONABLE AND CUSTOMARY: If a charge *incurred* by *you* or *your* covered *dependent* for services or supplies is in excess of the *reasonable and customary charge,* no payment will be made with respect to the excess amount of the charge. That part of the charge that is in excess of the *reasonable and customary charge* will not qualify as a *covered expense* under this *policy.]*

Premiums

From time to time, *we* will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, age and sex of *covered persons,* type and level of benefits, time the *policy* has been in force, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. Premium rates are expected to increase over time.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

DENTAL CLAIMS INCURRED PRIOR TO A TERMINATION DATE: Termination of insurance or termination of a benefit will not apply to a valid claim for benefits *incurred* before the termination date.

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate ActionInformation:	Attachments
Approved-Closed	Rates	GRI-DEN1-03	New		AR dental rates.pdf

Golden Rule Insurance Company
NAIC Number 0707-62286
Form Number: GRI-DEN1

Dental Premium Rate Exhibit for Arkansas

Premium rates are computed as follows:

- Note the appropriate region and tier.
- Select the benefit factor and the tier factor.
- Rounding to two decimals, let the monthly premium rate equal the product of the benefit factor, the cumulative adjustment factor and the tier factor.
- Rounding to two decimals, let the other modal premium rates be a multiple of the monthly premium rate (for instance, quarterly = 3 x monthly).

		Benefit Factor	
Region	**Filing ID >**	**A (150)**	**B (250)**
Arkansas		18.85	30.27
Out of State		19.79	33.30

Cumulative Adjustment Factor (CAF)	**A (150)**	**B (250)**
04/01/08	1.00000	1.00000
07/01/08	1.00000	1.00000
10/01/08	1.00000	1.00000
01/01/09	1.01500	1.01500
04/01/09	1.03000	1.03000
07/01/09	1.04500	1.04500
	| |	| |
	+ 0.015 / q.	+ 0.015 / q.

Tier Factor (TF)	**One Person**	**Two People**	**Three or more People**
Three-Tier	1.00000	1.98000	3.50000

Sample calculation of a premium rate

Suppose a family of four people living in Arkansas has selected dental benefit plan B (250) effective July 1, 2008. Then the factors and premium rates are as follows:

Benefit Factor	CAF	TF	Monthly	Quarterly	Semi-Annual	Annual
30.27	1.00000	3.50000	$105.95	$317.85	$635.70	$1,271.40

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Certification/Notice	Approved-Closed	06/23/2008

Comments:

Attachment:

Readability dental .pdf

		Review Status:	
Satisfied -Name:	Application	Approved-Closed	06/23/2008

Comments:

An updated application is attached to the form schedule tab.

		Review Status:	
Bypassed -Name:	Outline of Coverage	Approved-Closed	06/23/2008
Bypass Reason:	Outline of coverage is a new form and is attached under form schedule for review.		

Comments:

		Review Status:	
Satisfied -Name:	Cover letter	Approved-Closed	06/23/2008

Comments:

Attachment:

AR dental cover letter.pdf

READABILITY CERTIFICATION

We do hereby certify that in our judgement this filing is:

READABLE (simple sentence structure, shortness of sentences, use of common words, avoidance of legal and technical terms to greatest possible extent and defining of those terms which cannot be avoided, minimum cross references);

LEGIBLE (ample type size for text with contrasting type for headings and subheadings, ample space between lines, ample white space in margins and between sections, ample ink to paper contract); and

IN LOGICAL ORDER AND FORMAT (table of contents included, sections and subsections self-contained and arranged in logical flow, extensive use of headings and subheadings to facilitate location of particular items, outline form used where desirable for clarity).

Further, this filing meets or exceeds the requirements of the policy readability legislation currently effective in your state.

Certified by:

March 31, 2008
Date

Julie A. Van Straten
Vice President and General Counsel

Golden Rule®
A UnitedHealthcare Company

May 6, 2008

Via SERFF

Ms. Rosalind Mino
Arkansas Department of Insurance
Life, A&H, Annuities
1200 W. Third Street
Little Rock, AR 72201-1904

RE: Filing Submitted for Approval
Golden Rule Insurance Company
NAIC #: 707-62286
Company Tracking No.: GRI-DEN1-03

FORMS:

DV-AP-130	Application for Dental Insurance
GRI-DEN1-03	Dental Policy
GRI-DEN1-OC-03	Outline of coverage

Actuarial Memorandum and Rates
Readability Certification

Dear Mr. McBain:

We respectfully submit the attached individual dental insurance policy forms for your review and approval.

The dental insurance policy may be offered with a variety of deductible and coinsurance options. Therefore, the Data Pages should be considered variable in that they will be tailored to reflect the benefits as made available and selected by the individual insured.

Application form, DV-AP-130 is also attached for approval. We ask that the Coverage Information and Question section be considered variable. When this application is made part of a packaged sales presentation (i.e., prepared to accompany a brochure package describing the plans of coverage provided by a particular policy), these sections will be preprinted to allow an applicant to select a plan.

No part of this filing contains any unusual or possibly controversial items from normal company or industry standards.

We appreciate your time and attention to this filing. The Actuarial Memorandums and rates for these policy forms are attached for your review.

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62439
(618) 943-8000
www.goldenrule.com

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
(317) 297-4123
www.goldenrule.com

If there are questions or additional information is needed, please contact me at (800) 232-5432 extension 12969. My fax number is (920) 661-9861, and my email address is Jean.Davis@eAMS.com.

Sincerely,

Jean G. Davis
Manager Policy Compliance

Attachments

SERFF Tracking Number:	*AMMS-125636345*	*State:*	*Arkansas*
Filing Company:	*Golden Rule Insurance Company*	*State Tracking Number:*	*38875*
Company Tracking Number:	*GRI-DEN1-03*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*Dental policy/GRI-DEN1-03*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Application	05/06/2008	Dental application.pdf
No original date	Form	Dental Policy	05/06/2008	AR dental policy.pdf
No original date	Supporting Document	Application	05/06/2008	

Please Print
in blue Ink.

APPLICATION FOR [DENTAL/VISION] INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA

PROPOSED INSURED: _____ / / ❑Male ❑Female
First Name Middle Initial Last Name Birth Date Age Gender

MAILING ADDRESS: _____
Street (Include Apt.)

_____
City State [County] ZIP

A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.

PHYSICIAL ADDRESS: _____
Street (Include Apt.)

_____
City State ZIP

PHONE NUMBERS: (____) _____ (____) _____
Home Other Best number and times to call [E-mail Address]

DEPENDENTS: List below any dependents to be covered under the policy.

First Name	Relationship	Birth Date	Gender	First Name	Relationship	Birth Date	Gender
		/ /	❑M ❑F			/ /	❑M ❑F
		/ /	❑M ❑F			/ /	❑M ❑F
		/ /	❑M ❑F			/ /	❑M ❑F

PAYOR (If not You): _____
Name [E-mail Address]

_____
Street City State ZIP

[1. Total Annual Household Income: ❑$15,000 or less ❑$15,001 to $35,000 ❑$35,001 to $50,000 ❑$50,001 to $75,000 ❑$75,001 to $99,999 ❑$100,000 or more]

	Yes	No
[2. Have you or has any applicant lived in the 50 states of the USA or the District of Columbia for **less than** the past [12] months? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)]	❑	❑
[3. If you are applying for dental insurance, do you or does any applicant now have dental insurance that **will not** terminate prior to the requested effective date? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)]	❑	❑
[4. If you are applying for vision insurance, do you or does any applicant now have vision insurance that **will not** terminate prior to the requested effective date? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)]	❑	❑

PLAN CHOICE: ❑Plan 1 ❑Plan 2 ❑Plan 3

Optional Riders: ❑Rider 1 ❑Rider 2 ❑Rider 3

REQUESTED EFFECTIVE DATE: ____/____/____
(See Statement of Understanding section.)

Payment Option: ❑Monthly ❑Quarterly ❑Semi-Annually ❑Annually

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule [at its Indianapolis or Lawrenceville office] with this application; (b) if other [dental/vision] insurance exists that duplicates coverage under the [dental/vision] plan being applied for, the existing [dental/vision] coverage must be terminated prior to the effective date of this coverage; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that, for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that, for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule [at its Indianapolis or Lawrenceville office]. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X _____ X _____ X _____

Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child | State where you signed this application | Date you signed and read application

X _____ X _____

Licensed Agent or Broker (Please print.) | Individual Producer Number

IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule [at its Indianapolis or Lawrenceville office] more than 15 days after the date signed. Altered applications will not be accepted.

GOLDEN RULE

Golden Rule Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

In this *policy*, "*you*" or "*your*" will refer to the Insured named on page 3, and "*we*," "*our*," or "*us*" will refer to Golden Rule Insurance Company [, a stock company].

Section 1

AGREEMENT AND CONSIDERATION

We will pay benefits for a *loss* as set forth in this *policy.* This *policy* is issued in exchange for and on the basis of the statements made on *your* application and payment of the first premium. It takes effect on the applicable *effective date* shown [on the Data Page.] It will remain in force until the first renewal date, and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where *you* live.

GUARANTEED RENEWABLE SUBJECT TO LISTED CONDITIONS

You may keep this *policy* in force by timely payment of the required premiums. However, *we* may refuse renewal if: (A) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (B) there is fraud or a material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

From time to time, *we* will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, age and sex of *covered persons,* type and level of benefits, time the *policy* has been in force, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. Premium rates are expected to increase over time.

At least a [31] day notice of any plan to take an action or make a change permitted by this clause will be mailed to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made by a *covered person* under this *policy.*

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this *policy.* If *you* are not satisfied, *you* may notify *us* within 10 days after *you* received it. Any premium paid will be refunded, less claims paid. This *policy* will then be void from its start.

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect application may cause *your policy* to be voided, or a claim to be reduced or denied.

This *policy* is signed for *us* as of the *effective date* as shown [on the Data Page.]

Secretary

Dental Insurance Policy

This policy is renewable, subject only to the two conditions set forth in the renewal clause. We have the right to change premiums as set forth above.

COPY OF APPLICATION ATTACHED

Table of Contents

Section	
[1	Policy Face Page
	Agreement and Consideration
	Guaranteed Renewable Subject to Listed Conditions
	10-Day Right to Examine and Return This Policy
2	Data Page
3	General Definitions
4	Premiums
5	Dependent Coverage
6	Continuing Eligibility
7	Amount Payable
8	Dental Benefits
9	Exclusions/Limitations
10	Reimbursement
11	Termination
12	Claims
13	The Contract]

Important Notice

This Policy is a legal contract between *you* and *us*.

READ *YOUR POLICY* CAREFULLY.

Section 2
DATA PAGE

[Policy Number - 999-999-999
Insured - John Doe
[Plan [Choice] – Option A/Option B]
[Total Premium - $XXXX.XX]]

[**Premium Mode-[**Monthly/Quarterly/semi-annually/annually]]
[**First Renewal Date -** Month Day, Year]
Effective Date:

[See rider-amendment(s) attached to policy]

IMPORTANT: *Non-preferred providers* may bill *you* for any amount up to the billed charge after *we* have paid benefits due under this *policy*. *Preferred providers* have agreed to discounted pricing for *covered expenses* with no additional billing to you other than coinsurance and *deductible amounts*.

[DENTAL BENEFIT

[Waiting Period][No Waiting Period]

[*Preventive services* ..... [[3] months]
[*Basic services* ..... [[6] months]
[*Major services* ..... [[12] months]

[Deductible Amount] [per calendar year]

[Individual ..... [[$50 [per calendar year]]]
[Individual *Non-preferred provider* ..... [[$50 [per calendar year]]]
[Family ..... [[$150 [per calendar year]]]
[Family *Non-preferred provider* ..... [[$150[per calendar year]]]
[Combined *Preventive, Basic and Major services* ..... [[$50[per calendar year]]]
[Combined *Preventive, Basic and Major services Non-preferred provider*[[$50[per calendar year]]]
[Lifetime ..... [[$200]]
[Lifetime *Non-preferred provider* ..... [[$200]]
[Family Deductible Limit ..... [[3] individual deductibles [per calendar year]]
[*Preventive services* ..... [[$0] per person[per calendar year]]
[*Preventive services Non-preferred provider* ..... [[$0] per person[per calendar year]]
[*Basic* and *Major* services ..... [[$50] per person[per calendar year]]
[*Basic* and *Major services Non-preferred provider* ..... [[$50 per person[per calendar year]]

[Individual Maximum Benefit per Calendar Year ..... [[$1000]]
[***Non-preferred provider*** **Individual Maximum Benefit per Calendar Year** ..... [[$1000]]
[First Year ..... [[$500]
Second Year ..... [$750]
Third Year and following years ..... [$1000]]

[Coinsurance [Percentage]]

[*Preventive services* ..... [[100%]]
[*Preventive services Non-preferred provider* ..... [[100%]]
[*Basic services* ..... [[80%]]
[*Basic services Non-preferred provider* ..... [[80%]]
[*Major services* ..... [[50%]]
[*Major services Non-preferred provider* ..... [[50%]]
[X-rays ..... [[Basic][100%]]]
[X-rays *Non-preferred provider* ..... [[Basic][100%]]]

Section 3
GENERAL DEFINITIONS

In this *policy, italicized* words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy:*

- *"Basic service"* includes [dental exams,] [X-rays,] [routine extractions,] [palliative treatment for dental pain,] and [simple restorative service (filling)].

- *"Coinsurance percentage"* means the percentage of *covered expenses* that are payable by *us.*

- *"Covered expense"* means a *dental service* that is:
  - (A) *Incurred* while the *covered person* is insured under this *policy*;
  - (B) Prescribed, ordered, recommended, authorized or approved for a *covered person* by a *dentist*;
  - (C) *Dentally necessary*;
  - (D) Covered by a specific benefit provision specified in this *policy*;
  - (E) Not excluded in the *policy*; and
  - (F) Allowed under all other applicable terms and conditions of the *policy*.

We will not pay benefits for that part of a *covered expense* which:

- (A) Is subject to a *deductible amount* [or] coinsurance [or penalty];
- (B) Exceeds any applicable benefit maximum;
- (C) Exceeds the frequency limits described in the *policy*; or
- (D) Is subject to a *waiting period.*

We will not pay benefits for that part of a *covered expense* which exceeds:

- (A) The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option A]; or
- (B) The *reasonable and customary charge* for that expense if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option B].

- *"Covered person"* means *you, your spouse* and each *eligible child*: (A) named in the application and not excluded by *us*; or (B) whom *we* agree in writing to add as a *covered person.*

- *"Deductible amount"* means the amount of *covered expenses* [, shown in the Data Page,] that must actually be paid by [*you*] [each *covered person]* during any calendar year before any benefits are payable.

[A new [deductible] must be met each calendar year.*]*

[The maximum number of *covered persons* in a family that must meet the [deductible] in a calendar year is shown in the Data Page.]

- *"Dental emergency"* means severe pain, swelling or bleeding of the teeth or supporting tissue which occurs as the direct result of unforeseen events or circumstances and in the judgment of a reasonable person, requires immediate care and treatment which is sought or received within 24 hours of onset.

- *"Dental service"* means any of the following services or items that are provided for dental care or treatment provided by a *Dentist* to the teeth or supporting tissue:
  - (A) Consultation, advice, diagnosis, surgery, visit, or referral;
  - (B) Procedure, treatment, or other care;
  - (C) Supply, equipment; or
  - (D) Drug or medicine.

However, if a *policy* section describes only certain services or items as *dental services*, then *we* will only pay benefits under that section for those services or items. In addition, *we* will not pay benefits for any *dental service* unless it satisfies the definition of a *covered expense*.

- *"Dentally necessary"* means necessary from a dental perspective, satisfying all of the following requirements:
  - (A) Does not, exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment to the *covered person*;
  - (B) Is known to be safe, effective and appropriate by most U.S. *dentists* with regard to accepted standards of dental practice at the time when the *dental service* is provided;
  - (C) Cannot be provided primarily for the comfort or convenience of a *covered person* or *dentist*;
  - (D) Cannot be omitted without an adverse effect;
  - (E) Is appropriate for the *covered person's* diagnosis or symptoms; and

(F) Is the most cost-effective treatment that is appropriate for the *covered person's* diagnosis. This means there is no other similar or alternate [appropriate] *dental service* [as determined by *us*] available at a lower cost.

A final decision to provide *dental services* can only be made by the *covered person* and his/her *dentist.* However, *we* will determine if a *dental service* is *dentally necessary* based on *our* consultation with an appropriate [*dentist*] [consultant].

To determine what is *dentally necessary, we* may require copies of dental records with information to support that treatment, level or frequency of treatment or that the appliance or device is consistent with the dental condition.

The fact that any particular *dentist* may prescribe, order, recommend, or approve a treatment, test, or procedure does not, of itself, make the treatment, test, or procedure, *dentally necessary.* A determination of what is *dentally necessary* does not constitute a dental treatment decision.

• *"Dentist"* means a legally licensed dentist practicing within the scope of the license and currently licensed by the state in which the services are provided. *Dentist* also includes:

(A) A legally licensed oral surgeon, endodontist, periodontist, prosthodontist and pedodontist, practicing within the scope of his or her license; and

(B) A legally licensed dental hygienist practicing within the scope of the license while under the supervision of a *dentist.*

A *dentist* cannot be a family member of a *covered person.*

• *"Dependent"* means *your spouse* and/or an *eligible child.*

• *["Doctor"* means a duly licensed practitioner of the medical arts, limited to a physician holding an M.D. or D.O. degree. With regard to medical services provided to a *covered person*, a *doctor* must be currently licensed by the state in which the services are provided, and the services must be provided within the scope of that license. With regard to consulting services provided to *us*, a *doctor* must be currently licensed by the state in which the consulting services are provided.*]*

• *"Effective date"* means the [applicable] date a *covered person* becomes insured under this *policy.* The [applicable] *effective date* is shown: (A) [in the Data Page] of this *policy* for initial *covered persons*; and (B) on the rider adding any new *covered person.*

• *"Eligible child"* means *your* or *your dependent's* child, if that child is: (A) not married; and (B) under 26 years of age.

As used in this definition, "child" means: (A) a natural child; (B) a legally adopted child; (C) a child placed with *you* for adoption; or (D) a child for whom legal guardianship has been awarded to *you* or *your spouse.*

It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child. You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child.*

• *"Emergency palliative treatment"* means necessary procedures for the initial treatment of a *dental emergency.* This treatment does not include periodontal treatment or any *dental service* to restore or replace a tooth.

• *"Incurred"* means that a *dental service* has been provided to a *covered person* and a fee or charge is owed to the *dentist* for the service. *Covered expenses* for *dental services* will be considered to be *incurred* for:

(A) Appliances or a modification of appliances on the date the master impression is made;

(B) A crown, a bridge, a veneer or inlay or onlay restoration on the date the tooth or teeth are prepared;

(C) Root canal therapy on the date the pulp chamber is opened; and

(D) All other charges on the date the *dental service* is rendered or a supply furnished.

• *"Investigational treatment"* means a treatment that *we* determine meets one or more of the following criteria after consultation with a medical professional:

(A) The procedure, service, or supply is under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

(B) The procedure, service, or supply has not been determined through prevailing peer-reviewed medical literature to be safe and effective for the proposed use.

(C) In the case of a drug, device, or other supply that is subject to *USFDA* approval:

(1) It does not have *USFDA* approval;

(2) It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

(3) It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be: (a) included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or (b) safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications.

(D) The provider's research protocols indicate that the procedure, service, or supply is investigational or experimental.

Items (C) and (D) above do not apply to phase III or IV *USFDA* clinical trials.

• *"Loss"* means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

• *"Major service"* includes [endodontics,] [periodontics,] [major restorative services (crowns, inlays, onlays and veneers),] [prosthetics (bridges and dentures),][or][oral surgery for impactions,].

• *["Network"* means a *preferred provider* organization comprised of a group of *dentists* that contract with *us* to provide services covered by this plan at a contracted rate.]

• *["Non-preferred provider"* means a *dentist* who has not agreed with a *network* to provide *dental services* at the contracted rate.]

• *["Out-of-pocket expenses" means those expenses that a covered person is required to pay that qualify as covered expenses;]*

• *"Policy"* when *italicized*, means this policy issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

• *["Preferred provider"* means a *dentist* who has agreed with a *network* to provide *dental services* at the contracted rate and who is identified in the most current list of *preferred providers* for the *network* shown on the front of *your* dental identification card.]

• *"Preventive service"* includes [dental exams,] [X-rays,] [prophylactic cleaning,] [fluoride treatment,] [sealants,] and [space maintainers].

• *"Proof of loss"* means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, dental bills or records, other plan information, and network repricing information. [*Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.]

• *"Reasonable and customary charge"* means, with respect to fees charged, a fee calculated by *us* based on available data resources [(Ingenix Survey of Dental Charges)] of competitive fees in that geographic area. A fee will not be a *reasonable and customary charge* if it exceeds what the provider would charge any similarly situated payor for the same services. If a provider routinely waives [coinsurance and/or] the annual deductible for benefits, the fee for the dental *services* for which the [[coinsurance] and/or [the annual deductible]] are waived will not be a *reasonable and customary charge*.

Reasonable and customary charges are determined solely in accordance with *our* reimbursement policy guidelines. The reimbursement policy guidelines are developed by *us*, at *our* discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

(A) As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);

(B) As reported by generally recognized professionals or publications;

(C) As utilized for Medicare;

(D) As determined by medical or dental staff and outside medical or dental consultants;

(E) Pursuant to any other appropriate source or determination accepted by *us*.

• *"Residence"* means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* home address will be deemed to be *your residence*. If *you* do not file a United States income tax return, the location where *you* spend the greatest amount of time will be deemed to be *your residence*.

• *"Spouse"* means your lawful wife or husband.

• *"Waiting Period"* means a period of time for which a *covered person* must wait, after the *effective date* of coverage, before *dental services* listed in [Section 8: Dental Benefits] will be covered.

Section 4
PREMIUMS

PREMIUM PAYMENT: Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

GRACE PERIOD: *You* have until the 31st day following each premium due date to pay all premiums due. *We* may pay benefits for *your covered expenses incurred* during this 31-day grace period. Any such benefit payment is made in reliance on the receipt of the full premium due from *you* by the end of the grace period.

However, if *we* pay benefits for any claims during the grace period, and the full premium is not paid by the end of the grace period, *we* will require repayment of all benefits paid from *you* or any other person or organization that received payment on those claims. If repayment is due from another person or organization, *you* agree to assist and cooperate with *us* in obtaining repayment. *You* are responsible for repaying *us* if we are unsuccessful in recovering *our* benefits from these other sources.

[MISSTATEMENT OF AGE OR SEX: If a *covered person's* age or sex has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age or sex.]

[CHANGE OR MISSTATEMENT OF RESIDENCE: If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. [*Your* premium will be based on *your* new *residence* beginning on the first premium due date after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first premium due date *you* resided at that *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.]]

BILLING/ADMINISTRATIVE FEES: Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a [$20] fee for any check or automatic payment deduction that is returned unpaid.

Section 5
DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY: *Your dependents* become eligible for insurance on the later of: (A) the date *you* became insured under this *policy;* or (B) [the first day of the premium period after] the date of becoming *your dependent*.

EFFECTIVE DATE FOR INITIAL DEPENDENTS: The *effective date* for *your* initial *dependents,* if any, is shown [on the Data Page.] Only *dependents* for whom application has been made and approved by *us* will be covered on *your effective date*.

ADDING A NEWBORN CHILD: An *eligible child* born to or adopted within 90 days of birth by *you* or a *covered person* will be covered from the time of birth until [the 91st day] after birth.

Additional premium may be required to continue coverage beyond [the 91 st day] after the date of birth or adoption of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on [the 91st day] after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) any required premium within [90 days] of the child's birth.

ADDING OTHER DEPENDENTS: If: (A) *you* apply in writing for insurance on a *dependent*; (B) *you* pay the required premiums; and (C) *we* agree to insure the *dependent*; then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

Section 6
CONTINUING ELIGIBILITY

[For All Covered Persons: A *covered person's* eligibility for insurance under this *policy*] will cease on the earlier of:

(A) The date that a *covered person* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer for any portion of the premium for coverage under this *policy*; or

(B) The date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.]

[For Dependents: A *dependent* will cease to be a *covered person* at the end of the *premium period* in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date a *covered person* ceases to be a *dependent*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the *policy* month in which *we* receive the notice.

For Eligible Children:
A *covered person* will not cease to be an *eligible child* solely because of age if the *covered person* is: (A) not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and (B) mainly dependent on *you* for support.]

We may ask for proof of the *eligible child's* incapacity or dependency two months before the date the *dependent* would otherwise cease to be covered. *We* may require the same proof again, but *we* will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earliest of:

(A) The date the *policy* ends.

(B) The date all coverage for *you* and *your dependents* ends.

(C) The date the incapacity or dependency ends.

(D) The last due date of any premium period for which premium was paid, if premium for the subsequent premium period is not paid when due.

(E) [60] days after the date *we* request proof that is not given to *us*.

Section 7
AMOUNT PAYABLE

AMOUNT PAYABLE: *We* will pay the applicable *coinsurance percentage* in excess of the applicable *deductible amount* for the actual cost of services and supplies that:

(A) Qualify as *covered expenses* under each benefit provision; and

(B) Are received while the *covered person's* insurance is in force under this *policy*.

[The total amount payable for each *covered person* under this *policy* will not exceed the maximum benefit limit shown [in the Data Page.]]

INDIVIDUAL AND FAMILY DEDUCTIBLES:
[*You* and/or *your* covered *dependent* may have to pay an individual *deductible amount* before *we* pay any benefits. The *deductible amount* may apply per calendar year or per lifetime [as shown in the Data Page].]

[We may limit the number of deductibles for *you* and *your* covered *dependents* to a specific number of deductibles [as shown in the Data Page].]

CALENDAR YEAR MAXIMUM: The total amount *we* will pay [for certain types of *dental services,]* under this *policy,* may be limited to a yearly maximum [as shown in the Data Page]. The maximum applies each calendar year.

WAITING PERIOD: Benefits for certain types of *dental services* will not be payable until after a *waiting period* [as shown in the Data Page] has been satisfied.

COVERAGE UNDER OTHER POLICY PROVISIONS: Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy.*

[PREDETERMINATION: If the total cost for a dental treatment plan is expected to be [$300] or more, we strongly encourage *you* or *your* covered *dependent* or the *dentist* to request a predetermination from *us*. The request must include information about the treatment plan. *We* will tell the *dentist* what benefit amount *we* expect to pay, subject to the Alternate Procedures section.]

[Our estimate is valid for [180] days from the date *we* provide it to the *dentist,* as long as *your or your* covered *dependent's* insurance is in force when the *dental service* is *incurred.* If *you* or *your* covered *dependent* will not receive the *dental services* within the [180] days, *you* or *your* covered *dependent* or the *dentist* must request another predetermination from *us. Dental services* must be *incurred* while *you or your* covered *dependents* are insured by the plan.]

ALTERNATE PROCEDURES: If two or more services are considered to be acceptable to correct the same dental condition, the amount payable will be based on the *covered expenses* for the least expensive service that will produce a professionally satisfactory result as determined by *us* or *our* representatives.

If *you* decide or *your dentist* decides on a more costly treatment than *we* have determined to be satisfactory for treatment of the condition, payment will be subject to any applicable deductible amount and *coinsurance percentage* and will be limited to:

(A) The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option A]; or

(B) The *reasonable and customary charge* for that expense if [Section 2, Data Page, of this policy] identifies [your plan choice as Option B.

Section 8
DENTAL BENEFITS

DENTAL BENEFITS Benefits are limited to the *dental services* described below, per *covered person*, but only when each service is a *covered expense*:

(A) Oral evaluations (periodic, comprehensive and problem-focused) payable twice in any calendar year;

(B) Prophylaxis or cleaning teeth, payable twice in any calendar year;

(C) Topical fluoride for a *covered person* who is not yet age [16], payable twice in any calendar year. Topical fluoride treatment should be done in conjunction with dental prophylaxis;

(D) Full mouth (which includes bitewings) or panorex X-rays, payable once every [36] months. An exception will be made to the [36]-month limit if the full mouth or panorex X-rays are for diagnosis of third molars, cysts, or neoplasm;

(E) Up to four bitewing X-rays, payable [once] in any calendar year;

(F) Periapical X-rays;

(G) Sealants or preventive resin restorations, limited to once per first or second permanent molar every [36] consecutive months, for a *covered person* who is not yet age [16];

(H) Simple (nonsurgical) extractions;

(I) Injection of antibiotic drugs at the time of initial treatment;

(J) Palliative treatment when no other service, other than X-rays and exam, was done on the same tooth during the same visit;

(K) *Emergency palliative treatment* for dental pain;

(L) Amalgam fillings and direct resin fillings. Multiple restorations on one surface will be treated as a single filling;

(M) Analgesia, for a *covered person* who is not yet age [13];

(N) Sedative fillings as a separate benefit when no other service, other than X-rays and exam, was done on the same tooth during the same visit;

(O) Stainless steel crowns on primary teeth;

(P) Space maintainers to maintain space because of prematurely lost primary teeth, including the cost of recementing limited to once per lifetime, for a *covered person* who is not yet age [16]. This includes all adjustments within [6] months of installation;

(Q) Repair or recementing of crowns, inlays, onlays, veneers, bridgework, or dentures, relines and rebases, but not within [6] months of the initial placement and not more than once in any [12]-month period;

(R) Endodontic treatment, including root canals, pulpotomies on primary teeth and apicoectomy. To be a *covered expense*, pulpotomies performed on permanent teeth must be combined with the completed root canal;

(S) Periodontics, including procedures necessary for treatment of disease of the gums and bone-supporting teeth. Periodontal maintenance and gingival inflammation cleaning procedures are covered as routine prophylaxis benefits under *preventive services* if no active therapy has been performed. Active periodontal therapy means periodontal surgical or nonsurgical treatment.

Periodontal maintenance procedures are payable [twice] in any calendar year. Periodontal root planing and scaling is payable every [24]-month period, limited to four quadrants. Full mouth debridement is limited to [once] every [36] consecutive months.

The benefit for periodontal surgery includes three months of post-surgical care. Any periodontal surgery performed in the same quadrant within [36] consecutive months after the initial surgery was performed is not payable. If more than one surgical service is performed on the same day, only the most inclusive surgical service performed will be considered a *covered expense*;

(T) Osseous grafts with or without restorable or nonrestorable GTR membrane replacement are limited to once every consecutive [36] months per quadrant or surgical site;

(U) Pin retention, limited to [2] pins per tooth; this is not a *covered expense* if pin retention is in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays);

(V) Inlays, onlays, or veneers limited to one time per [60] consecutive months;

(W) Core buildup, cast and prefabricated post and core. Posts and cores are *covered expenses* only for teeth that have had a root canal therapy;

(X) First installation of bridgework to replace one or more functioning natural teeth lost while *you* or *your* covered *dependents* are insured by this plan. This includes inlays and crowns as abutments;

(Y) Full or partial dentures or overdentures, payable once every [5] years. The amount *we* will pay for overdentures will not exceed the benefit *we* would pay for full dentures;

(Z) Oral surgery, including surgical extractions and removal of impacted teeth. Charges for diagnostic xrays must be included in the charges for oral surgery to be *covered expenses*; and

(AA) General anesthesia, but only:

(1) For removal of impacted teeth;

(2) For removal of [seven] or more teeth; or

(3) If *dentally necessary* in conjunction with complex oral surgery.

For all *covered expenses*, the following *dental services* will be considered part of the entire *dental service* and not eligible for benefits as a separate service: cement bases; pulp caps; study models/diagnostic casts; acid etch; bonding agents; and local anesthetic.

Section 9
GENERAL EXCLUSIONS/LIMITATIONS

No benefits will be paid for any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services which are not *covered expenses*.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred for:

(A) Any expense or service related to that expense:

(1) That is not a *covered expense*;

(2) *Incurred* during the *waiting period*;

(3) To the extent that expense exceeds:

a. The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option A]; or

b. The *reasonable and customary charge* for that expense, if [Section 2, Data Page, of this *policy*] identifies [*your* plan choice as Option B].

(4) For which no benefit is described in the *policy* or [in the Data Page];

(5) For a *dental service* that is not rendered or that is not rendered within the scope of the *dentist's* license;

(6) For *dental services*, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under the Dental Benefits provision of this *policy*;

(7) Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service;

(8) For telephone consultations or for failure to keep a scheduled appointment;

(9) [For any *dental service* incurred directly or indirectly as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*;]

(10) For or while receiving *investigational treatment* or for complications there from, including expenses that might otherwise be covered if they were not *incurred* in conjunction with, as a result of, or while receiving *investigational treatment;*

(11) As a result of *dental services* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law; [or]

(12) As a result of:

a. Intentionally self-inflicted bodily harm (whether the *covered person* is sane or insane);

b. *Dental services* necessitated due to any act of declared or undeclared war;

c. The *covered person* taking part in a riot; [or]

d. The *covered person's* commission of a felony, whether or not charged.

(B) Any *dental service*:

(1) Provided by a government plan, program, hospital or other facility, unless by law *you* or *your* covered *dependent* must pay and it is otherwise a *covered expense;*

(2) Which by law must be provided by an educational institution;

(3) Which would be free of charge without this insurance, unless provided by Medicaid or by the Veterans Administration for non-service related *dental services* and which by law *we* are required to pay;

(4) Provided by a family member or by someone who ordinarily resides with *you* or *your* covered *dependent*;

(5) Provided prior to the *effective date* or after the termination date of this policy;

(6) Received outside of the United States, except for a *dental emergency*;

(7) For jaw-joint problems, including but not limited to: temporomandibular or craniomandibular joint dysfunction, myofunctional therapy, physical therapy;

(8) Relating to: teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by *us*;

(9) That is considered cosmetic dentistry, including, but not limited to: porcelain on a crown, abutment or pontics posterior to the second bicuspid; personalization or characterization of prosthetic devices; or composite restorations on molar and/or bicuspid teeth. Alternate services will be applied allowing benefits for amalgam restoration; bleaching; and services done to alter the shape or size of teeth. (Cosmetic services are those services that improve physical appearance);

(C) Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction;

(D) Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation;

(E) Orthognathic surgery to correct malposition of jaw bones;

(F) Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue;

(G) Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal;

(H) Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function;

(I) Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; replacement of orthodontic retainers; treatment splints; bruxism appliance; sleep disorder appliance; and gold foil restorations;

(J) Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; prescription and non-prescriptions drugs, with or without a prescription, unless they are dispensed and utilized in the dental office during *your* or *your* covered *dependents'* dental visit, except *we* will pay for injection of antibiotic drugs at the time of initial treatment; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures;

(K) Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are:

(1) Congenitally missing; or

(2) Lost before insurance under this *policy* is in effect.

However, benefits are available for *covered expenses* for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first [6] months following the date of placement, only if:

(1) The teeth were lost while the *covered person* was under the *policy* and the initial placement is within [12] months of the date of loss of the teeth; or

(2) The extraction took place while the *covered person* was both under age [16] and insured under this *policy*.

(L) Replacement within [60] consecutive months of the last placement for full and partial dentures and replacement within [60] consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within [12] months from the date the temporary service was installed;

(M) Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances inserted prior to plan coverage unless the *covered person* has been insured under the plan for [12] continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this [12]-month period, *dental services* associated with the addition will be covered when the service is a *covered expense*;

(N) Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the *Dentist*. If replacement is necessary because of *your* or *your dependents'* non-compliance, *you* are liable for the cost of the replacement;

(O) Dental implants and any related procedures, including but not limited to crowns, bridges, and dentures;

(P) Hospital or other facility charges and related anesthesia charges;

(Q) Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis;

(R) Local anesthetic; analgesia; and behavior management and conscious sedation;

(S) Charges for *dental services* that are not documented in the *dentist* records, not directly associated with dental disease or not performed in a dental setting ;

(T) Orthodontia;

(U) Acupuncture; acupressure and other forms of alternative treatment;

(V) Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations); or

(W) [Any *dental services* for which benefits are payable under a medical *policy* issued by *us*.]

EXCLUSION ON CHARGES IN EXCESS OF REASONABLE AND CUSTOMARY: If a charge *incurred* by *you* or *your* covered *dependent* for services or supplies is in excess of the *reasonable and customary charge,* no payment will be made with respect to the excess amount of the charge. That part of the charge that is in excess of the *reasonable and customary charge* will not qualify as a *covered expense* under this *policy.*

Section 10
REIMBURSEMENT

If a *covered person's dental services* are caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*. However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *dental services* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

(A) To fully cooperate with *us* in order to obtain information about the *loss* and its cause;

(B) To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;

(C) To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;

(D) That *we*:

(1) Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid;

(2) May give notice of that lien to any *third party* or *third party's* agent or representative;

(3) Will have the right to intervene in any suit or legal action to protect *our* rights;

(4) Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf;

(5) May assert that subrogation right independently of the *covered person*.

(E) To take no action that prejudices *our* reimbursement and subrogation rights;

(F) To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights;

(G) To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so;

(H) To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *dental services*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses;

(I) That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian (if the *covered person* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *covered person* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *covered person's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount a *covered person* must reimburse *us*, the *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

Definition: As used in this provision, the following term has the meaning indicated:

"Third party" means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *dental services*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Section 11
TERMINATION

TERMINATION OF POLICY: All insurance will cease on termination of this *policy*. This *policy* will terminate on the earliest of:

(A) Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;

(B) The date *we* receive a request from *you* to terminate this *policy*, or any later date stated in *your* request;

(C) The date *we* decline to renew this *policy*, as stated [in the Guaranteed Renewable provision];

(D) The date of *your* death, if no *dependents* are covered under this plan;

(E) [The date that a *covered person* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *policy*, or the date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;]

(F) The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in [the Continuing Eligibility section in this *policy*].

We will refund any premium paid and not earned due to *policy* termination.

If this *policy* includes *dependents*, it may be continued after *your* death: (A) by *your spouse*, if a *covered person;* otherwise, (B) by the youngest child who is a *covered person.*

This *policy* will be changed to a plan appropriate, as determined by *us,* to the *covered person(s)* that continues to be covered under it. *Your spouse* or youngest child will replace *you* as the insured. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

DENTAL CLAIMS INCURRED PRIOR TO A TERMINATION DATE: Termination of insurance or termination of a benefit will not apply to a valid claim for benefits *incurred* before the termination date.

REINSTATEMENT: If *your policy* lapses due to nonpayment of premium, it may be reinstated, upon payment of a [$50] reinstatement fee, provided:

(A) *We* receive from *you* a written application for reinstatement accompanied by the required reinstatement fee and premium payment within 60 days after the date coverage lapsed; and

(B) *We* approve the application in writing.

Premium required and accepted for reinstatement will be applied to the period for which premium had not been paid.

If *we* would not agree to insure *you* if *you* were applying initially for this *policy*, we will not reinstate coverage.

Section 12
CLAIMS

CLAIM FORMS: *We* will furnish claim forms after *we* receive notice of a claim. If *our* usual claim forms are not furnished within 15 days, *you* or *your* covered *dependent* may file a claim without them. The claim must contain written *proof of loss.*

NOTICE OF CLAIM: *We* must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

PROOF OF LOSS: *You* or *your* covered *dependent* must give *us* written *proof of loss* within [90 days] of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than [one year late] will not be accepted, unless *you* or *your* covered *dependent* had no legal capacity in that year.

COOPERATION PROVISION: Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

(A) Sign, date and deliver to *us* authorizations to obtain any dental, medical or other information, records or documents *we* deem relevant from any person or entity;

(B) Obtain and furnish to *us*, or *our* representatives, any dental, medical or other information, records or documents *we* deem relevant;

(C) Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask;

(D) Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our representative*, any information, records or documents requested by *us*).

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

TIME FOR PAYMENT OF CLAIMS: Benefits will be paid as soon as *we* receive proper *proof of loss.*

PAYMENT OF CLAIMS: Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a *beneficiary* who is a minor or is otherwise not competent to give valid release, *we* may pay up to [$1,000] to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *dental services*, directly to the *dentist* or other person providing such services, unless *you* provide other written direction no later than the time of filing *proof of loss.*

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. [*We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.]

FOREIGN CLAIMS INCURRED FOR DENTAL EMERGENCY CARE: Claims *incurred* outside of the United States for *dental emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical or dental records in English to show proper *proof of loss.*

MEDICAID REIMBURSEMENT: The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if: (A) a *covered person* is eligible for coverage under his or her state's Medicaid program; and (B) *we* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

CUSTODIAL PARENT: This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the noncustodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

(A) Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;

(B) Accept claim forms and requests for claim payment from the custodial parent; and

(C) Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *dentist* providing treatment to an *eligible child*.

DENTAL EXAM: At *our* expense, *we* have the authority to require *you* or *your* covered *dependent* to have a dental exam with a *dentist* at any time regarding a claim for benefits.

LEGAL ACTIONS: No suit may be brought by *you* on a claim sooner than [60 days] after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in [the complaint/grievance procedures made available to resolve disputes in *your* state of *residence* under *your policy*]. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date [*we* notified *you* of the final decision on *your* complaint/grievance].

[HEALTH INSURANCE FOR DENTAL SERVICES: If any *covered expenses* under this *policy* are also payable under health insurance or other health coverage, *we* will not make payment under this dental *policy* until after *we* determine what benefits are paid or payable by the health insurance or other health coverage plan.

Our payment under this *policy* will be reduced by the amount of any benefits that are payable for a *covered person* by any other dental or health plan.

[Your out-of-pocket expenses for dental benefits will not apply to *your out-of-pocket expenses* for medical benefits.]]

PROVIDER DISCOUNTS: *We* may have established an arrangement with certain *dentists* to offer a discount on services rendered. For the purposes of this provision, discount means any negotiated reduction or variation from the schedule of billed charges that a *dentist* otherwise would require a patient and/or *us* to pay to that *dentist*.

Section 13
THE CONTRACT

CONTRACT: This *policy*, with the application and any rider-amendments is the entire contract between *you* and *us*. No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy*. No agent may: (A) change this *policy*; (B) waive any of the provisions of this *policy*; (C) extend the time for payment of premiums; or (D) waive any of *our* rights or requirements.

NON-WAIVER: If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

TIME LIMIT ON CERTAIN DEFENSES: A misstatement by *you* in any application for this *policy* may be used to void this *policy* or to deny a claim. This action may be taken in the first two years, with no lapse, of a person's coverage. After the two-year period, this action may be taken only for a fraudulent misstatement.

REPAYMENT FOR FRAUD, MISREPRESENTATION OR FALSE INFORMATION: During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy*.

CONFORMITY WITH STATE LAWS: Any part of this *policy* in conflict with the laws of the state where *you* live on this *policy's effective date* is changed to conform to the minimum requirements of that state's laws.

CONDITIONS PRIOR TO LEGAL ACTION: On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must: (A) identify the coverage, benefit, premium, or other disagreement; (B) refer to the specific *policy* provision(s) at issue; and (C) include all relevant facts and information that support *your* position. Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within [30 days] after *we* receive *your* notice of intention to sue *us*.